	R MEDICARE & MEDIC	_						IB NO. 0938-0391	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	7	01	COMPL	LETED	
		155679	B. WIN		•		04/11/2	011	
		1	P. 1111		REET	ADDRESS, CITY, STATE, ZIP CODE	Ь		
NAME OF I	PROVIDER OR SUPPLIEI	₹				LSDALE DR			
BETHLE	HEM WOODS NUF	RSING AND REHABILITATION CI	ENTE						
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID		<u> </u>		(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PROVIDER'S PLA PREFIX (EACH CORRECTIVE A		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE	
K0000		,							
120000	 					l <u> </u>	_		
	A Life Safety C	ode Recertification	K(	0000		The creation and submission			
	and State Licer	isure Survey was				this Plan of Correction does not constitute an admission by this			
	conducted by t	the Indiana State				provider of any conclusion set			
	Department of	Health in				forth in the statement of			
	•	th 42 CFR 483.70(a).				deficiencies, or of any violation regulation. The provider	n of		
	Survey Date: 0	04/11/11				respectfully requests that the 2567 Plan of Correction be			
	Facility Nymalaa	0002C0				considered the Letter of Credi Allegation. Based on past sur			
	Facility Numbe			1		history and no harm identified	-		
	Provider Numb					any resident; this facility			
	AIM Number:	100267820				respectfully requests a desk			
						review in lieu of a post survey			
	Surveyor: Amy	/ Kelley, Life Safety				revisit on or before May 10, 20	J11.		
	Code Specialis	t							
	At this Life Saf	ety Code survey,							
	Bethlehem Wo	ods Nursing and							
		Center was found							
	not in complia								
	•								
	•	for Participation in							
	Medicare/Medi								
		0(a), Life Safety							
	from Fire and t	the 2000 edition of							
	the National Fi	re Protection							
	Association (N	FPA) 101, Life Safety							
		apter 19, Existing							
		ccupancies and 410							
	IAC 16.2.								
	IAC 10.2.								
	This one story	facility was							
	-	be of Type V (000)							
	construction a	* *							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G53421

Facility ID:

000260

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155679		A. BUIL	DING	NSTRUCTION 01	(X3) DATE S COMPL <b>04/11/2</b>	ETED	
		1.000.10	B. WIN		DDRESS, CITY, STATE, ZIP CODE	•=	
NAME OF P	ROVIDER OR SUPPLIER				SDALE DR		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CEN	TE	FORT V	VAYNE, IN46835		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
mo		ne facility has a fire		ing			DATE
	alarm system w	•					
	detection in the						
		he corridors. The					
		pacity of 90 and					
	=	f 88 at the time of					
	this survey.						
		Robert Booher, REHS, Life ist-Medical Surveyor on					
	The facility was compliance wit aforementioned requirements a following:	h the					
K0046   SS=C	duration is provide 19.2.9.1. Based on obser	•	K0	0046	It is the practice of this provide ensure that all battery operated		05/10/2011
	failed to ensure	h LSC 7.9. LSC			emergency light fixtures are fu operational by testing them at day intervals for a minimum of seconds and to keep written records of these tests. What corrective action(s) will be accomplished for those resider	lly 30 30	

li ´		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155679	B. WIN			04/11/2011
NAME OF	DDOWNED OD GUDDI IEI			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIEI			4430 E	LSDALE DR	
		RSING AND REHABILITATION CE	NTE		WAYNE, IN46835	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
		hting Equipment			found to have been affected b the alleged deficient practice:	· I
	requires a fund	ctional test shall be			residents were affected by the	
	conducted on	every required			alleged deficient practice. The	
	battery powere	ed emergency			Maintenance Supervisor has	
	lighting systen	n at 30 day intervals			tested all battery operated	_
	for a minimum	of 30 seconds.			emergency lights for at least 3	
	Equipment sha				seconds and has documented such tests. The	
		the duration of the			Maintenance Supervisor will	
	I -	ecords of visual			continue to test all emergency	,
					lights on a monthly basis for a	
	I -	d tests shall be kept			least 30 seconds and these te	
	1 -	or inspection by the			will be documented in the writ	l l
	authority havir	ng jurisdiction. This			record.How will you identify ot residents having the potential	l l
	deficient pract	ice could affect all			be affected by the same allege	
	resident, staff	and visitors.			deficient practice and what	
					corrective action will be taken:	:All
	Findings include	de:			residents have the potential to	l l
					affected by the alleged deficie	nt
	   Based on an ol	oservations with the			practice. The Maintenance Supervisor will test and docun	aont
		upervisor and the			the testing of the emergency	ient
					lights monthly in the Preventa	tive
	1	/Laundry Supervisor			Maintenance Manual and the	
		rom 10:40 a.m. to			Executive Director will review	<b>I</b>
		nt battery operated			Preventative Maintenance Ma	
		nts were observed			each month and sign off that t emergency light testing was	ne
	throughout the	e facility. Based on			completed and documented.V	/hat
	an record revie	ew with the			measures will be put into place	
	Maintenance S	upervisor at 10:30			what systemic changes you w	ill
	a.m., documen	itation of a monthly			make to ensure that the allege	ed
	1 '	onth of October			deficient practice does not	
		available for review.			recur:The Maintenance Supervisor will to	2et
		terview with the			and document the testing of the	
		upervisor at the			emergency lights monthly in the	
		•			Preventative Maintenance Ma	
		review, no other			and the Executive Director wil	1
	documentation	n was available for			review the Preventative	

PRINTED: 04/27/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155679		155679	A. BUILDI		01 	COMPL 04/11/20	ETED
		100019	B. WING			U <del>-1</del> /11/20	711
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
BETHLEI	HEM WOODS NUR	SING AND REHABILITATION CEN			SDALE DR /AYNE, IN46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	l	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	l	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1.	AG			DATE
K0051	installed according Alarm Code, to profire in any part of the complete fire a fire alarm initiation extinguishing syst in patient sleeping provided that man 200 feet of nurse's located in the path written records of reliable second so Fire alarm system accordance with Maintenance are left.	ces or equipment is g to NFPA 72, National Fire ovide effective warning of the building. Activation of alarm system is by manual and automatic detection or the emoperation. Pull stations areas may be omitted aual pull stations are within a stations. Pull stations are in of egress. Electronic or the tests are available. A purce of power is provided. It is are maintained in the provided are applied to the provided of the provide			Maintenance Manual each mo and sign off that the emergence light testing was compelted and documented. The Maintenance Director will also be re-inservice by May 10, 2011. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recure CQI monitoring tool will be utility weekly x 4, monthly x 3 and quarterly thereafter. Data will be submitted to the CQI committee If threshold is not met, an action plan will be developed. Non-compliance with facility policy/procedure may result in disciplinary action and/or re-education.	elected  deced  deced  zed  be elected	
SS=E			K005	1	It is the practice of this provide ensure that no smoke detector are installed where air flow wo	s	05/10/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G53421

Facility ID:

000260

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155679		(X2) MU A. BUII B. WIN	LDING G	NSTRUCTION  01	(X3) DATE SURVEY COMPLETED 04/11/2011		
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NUR	SING AND REHABILITATION CE	STREET ADDRESS, CITY, STATE, ZIP CODE  4430 ELSDALE DR  ENTE FORT WAYNE, IN46835					
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
the 100 hall an were not instal would adversel operation. NFF requires in spath handling system not be located prevents operadetectors. This could affect an residents on the resident in the event of an em  Findings include Based on an ob-Maintenance Staundry/House on 04/11/11 ft 12:00 p.m., on detectors on the located within supply air duct Additionally, or detectors in the located within supply air duct apply air duct	PA 72, 2-3.5.1 ces served by air ms, detectors shall where air flow tion of the s deficient practice y of the 32 e 100 hall and any Beauty Shop in the ergency. e: eservations with the upervisor and the ekeeping Supervisor rom 11:30 a.m. to e of the five smoke the 100 hall was three feet of a and a return. ne of one smoke e Beauty Shop was three feet of an . This was by the Maintenance			adversely affect their operation. What corrective action(s) will be accomplished those residents found to have been affected by the alleged deficient practice: No resident were adversely affected. Two smoke detectors in the 100 ha and the Beauty Shop were more so that air flow would not adversely affect their operation. How will you identify others having the potential to laffected by the same alleged deficient practice: All resident have the potential to be affected by the same alleged deficient practice. The Maintenance Supervisor will tour the entire facility to ensure that no other smoke detectors are installed where air flow would adversely affect their operation. If any a found, the Maintenance Supervisor will make sure they are moved so that air flow will adversely affect their operation. What measures will put into place or what systemic changes you will make to ensuthat the alleged deficient practices not recur: The Maintenance Supervisor will tour the enitre facility to ensure that no other smoke detectors are installed where air flow would adversely affect their operation. If any a found, the Maintenance Supervisor will make sure they are moved so that air flow will adversely affect their operation. If any a found, the Maintenance Supervisor will make sure they are moved so that air flow will adversely affect their operation. If any a found, the Maintenance Supervisor will make sure they are moved so that air flow will adversely affect their operation. If any a found, the Maintenance Supervisor will make sure they are moved so that air flow will adversely affect their operation. If any a found, the Maintenance Supervisor will make sure they are moved so that air flow will adversely affect their operation.	ts  Ill oved  / be sed  / re / not be ccure ice cce / re / not n.		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO	NSTRUCTION 01	(X3) DATE S COMPL		
111121211	or confidence.	155679	A. BUILD B. WING	ING		04/11/20	
	PROVIDER OR SUPPLIER HEM WOODS NUR	SING AND REHABILITATION CEN		4430 EL	DDRESS, CITY, STATE, ZIP CODE  SDALE DR VAYNE, IN46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0052	installed, tested, a accordance with N Code and NFPA 7 approved mainten	IFPA 70 National Electrical  2. The system has an ance and testing program plicable requirements of			be re-inserviced on acceptable locations for installation of smodetectors. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur: A CQI monitoring tool will be utilized every week x 4, monthly x 3 at quarterly thereafter. Data will submitted to the CQI committer of threshold is not met, an action plan will be developed. Non-compliance with the facility policy/procedure may result in disciplinary action and/or re-education.	nd be ee. on	
SS=C	fire alarm system with NFPA 72, Code. NFPA 72 trouble signals area where it is NFPA 72, 1–5.4 alarms, supervitrouble signals and descriptive	acility failed to and maintain 1 of 1 ams in accordance National Fire Alarm 2, 1–5.4.6 requires to be located in an likely to be heard. 4.4 requires fire sory signals, and to be distinctive	K00	952	It is the practice of this provide ensure that the fire alarm systis properly tested and maintained. What corrective action(s) will be accomplished those residents found to have been affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. How you will identify other residents having potential to be affected by the same alleged deficient practice and what corrective action will taken: All residents have the potential to be affected by the same deficient practice. The Maintenance Supervisor will contact a fire alarm specialty	em for s the	05/10/2011

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Event ID:

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Facility ID:

000260

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE								
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED				
		155679	B. WIN			04/11/2011				
NAMEOUS	DROVIDED OF GURBLIEF	,		STREET A	ADDRESS, CITY, STATE, ZIP CODE					
NAME OF I	PROVIDER OR SUPPLIER	i.		4430 ELSDALE DR						
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CE	NTE	1	WAYNE, IN46835					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	1	ID		(X5)				
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION				
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE				
	Findings includ	le:			company and have that compa	any				
					assess and fix the fire alarm					
	Rased on an ob	servation with the			system, most specifically making	<u> </u>				
					sure the trouble signal is in an					
		upervisor and the			area where it is likely to be he and will make sure the reason					
		Laundry Supervisor			the trouble lamp illumination is					
	on 04/11/11 a	t 1:55 p.m., when			identified and fixed.What					
	the automatic	dialer component			measures will be put into place	e or				
	was placed in t	rouble from phone			what systemic changes you w					
	· ·	ocal trouble was			make to ensure that the allege	ed				
	·	dialer component			deficient practice does not					
		the communication			recur:The Maintenance Supervisor will contact a fire					
		ont Administration			alarm specialty company and					
					have that company asses and	fix				
		not continually			the fire alarm system, most					
	· ·	trouble signal was			specifically making sure the					
	not transmitted	d to the main fire			trouble signal is located in an					
	alarm panel or	any other			area where it is likely to be he					
	continuously o	ccupied location.			and making sure the reason for the trouble lamp illumination is					
	I -	nal was not located			identified and fixed. The					
		re it was likely to be			Maintenance Supervisor will b	e				
		nally, the trouble			re-inserviced on the important					
		• •			of properly testing and					
	lamp was illum				maintaining the fire alarm					
	automatic diale	•			system. The Maintenance					
		uble with the DACT			Supervisor will check the fire alarm system for proper opera	tion				
	(Digital Alarm (	Communicator			on no less than a monthly bas					
	Transmitter). I	Based on an			and will include ensuring the					
	interview with	the Maintenance			trouble signal is likely to be he	ard				
	Supervisor at tl	he time of			and will make sure the trouble					
	· .	e was not aware the			light is not illuminated, and if s	0,				
	trouble light w				will ensure the problem is identified and fixed					
	i duble light w	as manimatea.			immediately. The Maintenance	_				
	2.1.10/5				Supervisor will document the					
	3.1-19(b)				monthly checks in the					
					Preventative Maintenance					
					manual and these checks will	be				
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID: G	53421	Facility	ID: 000260 If continuation s	heet Page 7 of 17				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155679		(X2) MU A. BUII B. WIN	DING	NSTRUCTION  01	(X3) DATE S COMPL <b>04/11/2</b> (	ETED	
	PROVIDER OR SUPPLIER	II SING AND REHABILITATION CEN	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE  LSDALE DR  VAYNE, IN46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0056		matic sprinkler system, it is lance with NFPA 13,			signed off by the Executive Director on a monthly basis.Ho the corrective action(s) will be monitored to ensure the allege deficient practice will not recur CQI monitoring tool will be utili every week x 4, monthly x 3 ar quarterly thereafter. Data will submitted to the CQI committe If threshold is not met, an actio plan will be developed. Non-compliance with the facilit policy/procedure may result in disciplinary action and/or re-education.	ed :A zed nd be ee. on	
SS=E	Standard for the list Systems, to provide portions of the built properly maintained 25, Standard for the Maintenance of W. Systems. It is fully reliable, adequated system. Required equipped with wat switches, which at the building fire all 1. Based on obtain the property on the property on the property on the property of the provided in 1 of 1 Cottages of Sprinkler Systems.	nstallation of Sprinkler de complete coverage for all lding. The system is ed in accordance with NFPA ne Inspection, Testing, and later-Based Fire Protection ly supervised. There is a ly water supply for the la sprinkler systems are leter flow and tamper are electrically connected to larm system. 19.3.5 loservation and lacility failed to letype of sprinkler laresponse or lacklers were installed loge dining rooms. Edition, Installation listems, 5–3.1.5.2	K	056	It is the practice of this provide ensure that the automatic sprinkler system is installed an maintained properly. What corrective action(s) will be accomplished for those resider found to have been affected by the alleged deficient practice: No residents were found to have been affected by the alleged deficient practice. How you will	nts y No	05/10/2011
	in 1 of 1 Cottag NFPA 13, 1999 of Sprinkler Sys	ge dining rooms. Edition, Installation stems, 5–3.1.5.2 isting light hazard			found to have been affected by the alleged deficient practice:N residents were found to have been affected by the alleged	y No	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155679	B. WIN			04/11/20	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		4430 EI	LSDALE DR		
	HEM WOODS NUR	RSING AND REHABILITATION CEN	NTE	FORT V	WAYNE, IN46835		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	·	_	DATE
	quick response				same alleged deficient practice and what corrective action will		
	sprinklers, all s	sprinklers in a			taken: All residents have the		
	smoke compar	tment shall be			potential to be affected by the		
	changed. This	deficient practice			same alleged deficient practice		
	could affect an	y of the 19 Cottage			The Maintenance Supervisor v	vill	
	residents who	might be in the			contact a specialty sprinkler	ıro	
		room at the time of			system company and will ensuthat all of the same type of	ii <del>C</del>	
	an emergency.				sprinkler heads are installed o	n	
	an emergency.				the Cottage; that the armover		
	   Findings includ	la.			the sprinkler pipe above the		
	Findings includ	ie.			celing tile near the D wing fire		
					doors is properly supported; the sprinkler head installed ab		
		rvations with the			the dryers is moved at least 4	ove	
	Maintenance Si	•			inches from the wall.What		
	Housekeeping,	Laundry Supervisor			measures will be put into place	e or	
	and the Admin	istrator on			what systemic changes you wi		
	04/11/11 at 1	1:05 a.m., the			make to ensure that the allege	:d	
	Cottage dining	room had what			deficient practice does not recur:The Maintenance		
	appeared to be				Supervisor will contact a speci	altv	
		kler heads with the			sprinkler system company and	-	
		and six standard			will ensure that all of the same	;	
	_	kler heads. Based			type of sprinkler heads are		
	on an interview				installed on the Cottage; that t	ne	
					armover of the sprinkler pipe above the ceiling tile near the	n	
		at 11:10 a.m., she			wing fire doors is properly		
		.E Inc. regarding			supported; that the sprinkler he	ead	
		was told it is the			installed above the dryers is		
	practice of P.I.I	P.E to install quick			moved at least 4 inches from t	he	
	response sprin	kler heads when			wall. The Maintenance	۱	
	any sprinkler h	ead requires			Supervisor will be re-inservice on the importance of proper	u	
	replacing. The	Administrator			installation and maintenance of	of	
	stated the spri				the facility's sprinkler system.		
	question developed leaks.				the corrective action(s) will be		
		- 1			monitored to ensure the allege		
	3.1-19(b)				deficient practice will not recur		
	J.1-19(D)				CQI monitoring tool will be utili	zeu	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155679		.: A. BU	JILDING	01	COI	TE SURVEY MPLETED 1/2011	
		100010	B. W.		ADDRESS, CITY, STATE, ZIP C		
NAME OF P	PROVIDER OR SUPPLIER			1	LSDALE DR	.022	
BETHLE	HEM WOODS NUR	SING AND REHABILIT	TATION CENTE	FORT \	WAYNE, IN46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCE	ES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY LSC IDENTIFYING INFORM	I	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETION DATE
	2. Based on ob	oservation and			every week x 4, month quarterly thereafter. I submitted to the CQI	Data will be	
	interview, the f				If threshold is not met	, an action	
		rmovers on the			plan will be developed Non-compliance with		
	-	m was supported in	ו		policy/procedure may		
		h NFPA 13, 1999 n 6-2.3.4 states th	_		disciplinary action and re-education.	d/or	
		izontal length of a	I		16-Euucati011.		
	unsupported a	_					
	sprinkler, sprin	kler drop, or					
	sprig-up shall	not exceed 24					
	inches for stee	pipe or 12 inches					
		e. These deficient					
	practices could						
		e main dining room	1				
	and the Beauty	snop.					
	Findings includ	le:					
l	Based on obser	vation with the					
		pervisor and the					
		Laundry Superviso	r				
	· · ·	t 1:45 p.m., there					
		orted armover of					
	the sprinkler pi	ipe measuring :hes in length abov					
	-	near the D wing fir					
	doors.	a. the b wing in	`				
		wledged by the					
		upervisor at the					
	time of observa	ations.					
	3.1-19(b)						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete E	vent ID: G5342	1 Facility	ID: 000260 If co	ntinuation sheet	Page 10 of 17

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155679	B. WIN	G		04/11/2	011
NAME OF P	ROVIDER OR SUPPLIEF	<u>.</u>	•		ADDRESS, CITY, STATE, ZIP CODE	•	
DET!!! E!	LIEMANNOODO NILIE	AOINIO AND DELLABILITATION OF		1	LSDALE DR		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CEI	NIE	FORT	WAYNE, IN46835		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	3. Based on ol						
		acility failed to					
	ensure 1 of 1 s						
		the dryers was at					
		es from the wall.					
	NFPA 13, 5-6.3	3.3 requires upright					
	and pendant s	orinkler heads shall					
	be installed at	least four inches					
	from the wall.	This deficient					
	practice was no	ot in a resident care					
	area but could	affect and number					
	of staff.						
	Findings includ	le:					
	. 5.						
	Based on obse	rvation with the					
		Laundry Supervisor					
		it 12:15 p.m., the					
		above the dryers					
	•	wo inches from the					
		acknowledged by					
	the Housekeep	- ·					
	Supervisor at t	ne time of					
	observation.						
	2.1.10/5						
	3.1-19(b)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155679	B. WIN			04/11/2	U11
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CE	NTE	1	LSDALE DR WAYNE, IN46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0061 SS=F	Required automat valves supervised alarm will sound w NFPA 72, 9.7.2.1 Based on obser interview, the frensure 1 of 1 P valve) was elect supervisor. The affects all occur findings includ Based on obser Maintenance Sultousekeeping/on 04/11/11 at PIV was in the control tamp observed on the interview with the Supervisor at the supervisor	ic sprinkler systems have so that at least a local when the valves are closed.  vation and acility failed to live (post indicator cronically is deficient practice pants.  e:  vation with the apervisor and the Laundry Supervisor to 10:58 a.m., the open position with oved. No per device was a PIV. Based on an other Maintenance are time of e handle is kept in	K	0061	It is the practice of this provide ensure that the the automatic sprinkler system has valves supervised so that at least a leal alarm will sound when the valuare closed. What corrective action(s) will be accomplished those residents found to have been affected by the alleged deficient practice: No residen were found to have been affected by the alleged deficient practice. How you will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will taken: All residents have the potential to be affected by the same alleged deficient practice. The Maintenance Supervisor contact a specialty sprinkler system company and ensure an electronic tamper device is installed on the Post Indicator Valve. The Maintenance Supervisor will also ensure that the handle is on the Post Indicator Valve. The Maintenance Supervisor will be re-inserviced on the requirement of keeping an electronic tamper device on the PIV and keeping the handle on the PIV. What measures will be put into place what systemic changes you were supervisor will be put into place what systemic changes you were supervisor will be put into place what systemic changes you were supervisor will be put into place what systemic changes you were supervisor will be put into place what systemic changes you were supervisor will be put into place what systemic changes you were supervisor will be put into place what systemic changes you were supervisor will be put into place.	e e. will that ee ents er g	05/10/2011

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/11/2011		
NAME OF PROVIDER OR SUPPLIER  BETHLEHEM WOODS NURSING AND REHABILITATION CEN			STREET ADDRESS, CITY, STATE, ZIP CODE  4430 ELSDALE DR				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K0062	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA			make to ensure that the allege deficient practice does not recur: The Maintenance Supervisor will contact a spec sprinkler system company and ensure that an electronic tamp device is installed on the Post Indicator Valve. The Maintena Supervisor will also ensure that the handle is on the Post Indicator Valve. The Maintenance Supervisor will be re-inserviced on the requirement of keeping an electronic tamped device on the PIV and keeping the handle on the PIV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur CQI monitoring tool will be util every week x 4, monthly x 3 a quarterly thereafter. Data will submitted to the CQI committed If threshold is not met, an action plan will be developed.  Non-compliance with the facility policy/procedure may result in disciplinary action and/or re-education.	ialty dependence at  e ents er de condence de		
SS=C	-	acility failed to plete supply of s for the automatic m in accordance	K0062	It is the practice of this provide ensure that a complete supply spare sprinklers for the autom sprinkler system are stored on the premises. What correcti action(s) will be accomplished those residents found to have been affected by the alleged	of atic ve for		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679		(X2) MI A. BUII B. WIN	LDING	onstruction 01	(X3) DATE SURVEY COMPLETED - 04/11/2011		
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR				
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE			
2-4.1.4 which rat least six spar be stored in a copremises for repurposes. The sprinklers shall representative of temperature rat sprinklers. A magninklers of eatemperature rat be provided. The practice could a if the sprinkler shut down becasprinkler wasn't replacement.  Findings included Based on observing Maintenance Sure O4/11/11 at 11 vial sprinkler head in the Cottage of asked to retrieve sprinkler head of sprinkler head of sprinkler head of Maintenance Sure President Sure Pr	equires a supply of se sprinklers shall abinet on the clacement stock of spare be proportionally of the types and ings of the system inimum of two ch type and ing installed shall his deficient all residents system had to be use a proper available as a secured when the pervisor on 100 a.m., thin glass hads were observed lining room. When this type of from the spare cabinet, the pervisor stated prinkler heads of		IAU	deficient practice: No resident have been affected by the alle deficient practice. How you will identify other residents having potential to be affected by the same alleged deficient practic and what corrective action will taken: All residents have the potential to be affected by the same alleged deficient practic. The Maintenance Supervisor ensure a supply of at least 6 spare sprinklers are stored or premises for replacement purposes, including two sprint of each type and temperature rating that are installed. What measures will be put into place what systemic changes you we make to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor will ensure a supple at least 6 spare sprinklers are stored on the premises for replacement purposes, include two sprinklers of each type are temperature rating that are installed. The Maintenance Supervisor will be re-inservice on the necessity to keep a sufficient back up supply of existing types of sprinklers on premises. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur: A CQI monitoring tool will be utilized every week x 4, monthly x 3 a quarterly thereafter. Data will submitted to the CQI committed to the C	eged I I I the I be I b	DATE	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY	
		IDENTIFICATION NUMBER:		A. BUILDING 01		COMPLETED	
		155679	B. WING			04/11/2011	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF FROVIDER OR SUFFLIER					LSDALE DR		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION CEN	NTE	FORT V	WAYNE, IN46835		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	3.1-19(b)				plan will be developed.  Non-compliance with the facility policy/procedure may result in		
					disciplinary action and/or	ciplinary action and/or	
					re-education.		
K0064		guishers are provided in all ancies in accordance with					
		6, NFPA 10					
SS=B	1. Based on ob	servation and	K0064		It is the practice of this provide		05/10/2011
	interview, the f	acility failed to			ensure portable fire extinguish are inspected timely and	ensure portable fire extinguishers	
	inspect 2 of 2 f	ire extinguishers			documentation of the inspection		
	observed in the resident's lounge and the main nurses' station each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being				is performed timely.What corrective action(s) will be accomplished for those residents found to have been affected by		
					the alleged deficient practice: No residents were found to have		
					been affected by the alleged		
					deficient practice.How you will identify other residents having the		
					potential to be affected by the		
					same alleged deficient practice		
		ddition, NFPA 10,			and what corrective action will	be	
	Section 4-2.1 c	defines inspection			taken: All residents have the potential to be affected by the		
		ck" to ensure the			same alleged deficient practice	e.	
	<del>-</del>	er is available and			The Maintenance Supervisor		
	will operate. It is intended to give				has inspected the 2 fire extinguishers in the resident's		
	reasonable assurance the fire				lounge and at the main nurses	<b>;'</b>	
	extinguisher is fully charged and				station and has documented as		
	operable, verify	ring that it is in its			such. The Maintenance Supervisor will contact a specialty		
	designated plac	ce, it has not been			fire system company and ensu		
	actuated or tan	npered with and			that the K-class portable fire extinguisher in the kitchen		
	there is no obv	ious or physical					
	~	dition to prevent its			receives proper maintenance and is tagged as such.What		
	operation. This deficient practice could affect all residents in the				measures will be put into place or		
					what systemic changes you wi		
resident's lounge and at the main		ge and at the main			make to ensure that the allege	:d	

000260

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN		01	COMPLETED	
		155679	A. BUILDING B. WING		-	04/11/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LSDALE DR		
BETHLEHEM WOODS NURSING AND REHABILITATION CEN							
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
	nurses' station	in the event of an			deficient practice does not recur:The Maintenance		
	emergency.				Supervisor has inspected the		
	er droot of old	L			fire extinguishers in the reside	nt's	
	Findings includ	ie:			lounge and at the main nurses station and has documented a		
	Based on observations with the				such. The Maintenance Supervisor will contact a spec	ialty	
	Maintenance Si	upervisor and the			fire system company and ensi	ure	
	Housekeeping/	Laundry Supervisor			that the K-class portable fire		
	on 04/11/11 f	rom 11:40 a.m. to			extinguisher in the kitchen	and	
	12:02 p.m., the monthly inspection tag on the resident's lounge fire extinguisher lacked documentation of a monthly				receives proper maintenance is tagged as such. The	anu	
					Maintenance Supervisor will b	e	
					re-inserviced on the required		
					maintenance and timeframe for		
		•			maintenance of K-class portal	ole	
	inspection for the months of February and March 2011 and the				fire extinguishers and will continue with required		
	=				checks.How the corrective		
	fire extinguish				action(s) will be monitored to		
	nurses' station				ensure the alleged deficient		
	documentation				practice will not recur: A CQI		
	-	the month of March			monitoring tool will be utilized every week x 4, monthly x 3 a	nd	
	2011. This wa	s acknowledged by			quarterly thereafter. Data will		
	the Maintenand	ce Director at the			submitted to the CQI committee		
	time of observa	ation.			If threshold is not met, an action	on	
	3.1-19(b)				plan will be developed.		
					Non-compliance with the facili policy/procedure may result in	-	
	2 Rased on ob	2. Based on observation and			disciplinary action and/or re-education.		
	interview, the facility failed to ensure 1 of 1 K-class portable fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six				3443413111		
	years as requir	ed by NFPA 10,					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155679		A. BUILDING  B. WING		COMP	COMPLETED 04/11/2011			
NAME OF PROVIDER OR SUPPLIER  BETHLEHEM WOODS NURSING AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	deficient practi resident care a any number of Findings includ Based on obser Maintenance St 04/11/11 at 12 maintenance ta fire extinguishe indicated the la completed Janu	Chapter 4-4.3. This ce was not in a rea but could affect staff.  The ce:  The could affect staff.  The could affect staff						